Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Peter E Grays

Respondent Name
Commerce & Industry Insurance

MFDR Tracking Number
M4-14-0508-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…once the surgical incision is made and either of these surgical encounters takes place, they should be considered necessary indicated as part of the compensable injury surgical session and were sent prior for prior authorization."

Amount in Dispute: $1,750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that there is no additional money owed to the requestor, Peter Grays, MD for the 10/23/2012 surgical procedure. Te bill has been audited two separate times, 11/16/2012 when a check was issued in the amount of $2,390.58 and again on 5/9/2013 when an additional $524.21 check was issued on 5/13/2013; for a total of $2,914.79. I have attached the two EOR's. The bill was paid in accordance with the Workers Compensation State Fee Guidelines. The Carrier is going to maintain their denial that the additional $1750.00 is not owed to the requestor, Dr. Peter Grays, MD."

Response Submitted by: AIG, 4100 Alpha Road, Suite 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2012	55520, 64774	$1,750.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 59 – Processed based on multiple or concurrent procedure rules
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

1. Did the requestor support that additional reimbursement is due?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, "97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 28 Texas Labor Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. Review of the submitted codes find the following;
    a. Procedure code 55520, 59 – Add on code, and that this separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported.
    b. Procedure code 644774, 59 – Per CCI edits; this code is allowed when billed with appropriate modifier and supported documentation. Documentation to support use of the 59 modifier is defined as, "Distinct Procedural Service - Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. Review of the submitted operative report does not support a distinct procedure service. The carrier's denial is supported.
2. The Division finds no additional payment can be recommended based on Rule 134.203.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 23, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.